

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4679

CERTIFICATE OF DEATH

Reg. Dist. No.

04671

| | | | |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. LENGTH OF STAY IN 1b 25 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Agnes M Atkinson | | 4. DATE OF DEATH Month Day Year April 14, 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 26, 1866 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Home nursing | |
| 11. BIRTHPLACE (State or foreign country) Great Britain | | 12. CITIZEN OF WHAT COUNTRY? Great Britain | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Hosp. records | | Address Chestertown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd and 3rd degree thermal burns of body 917.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 8 days |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped in tub of hot water | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. 1:00 PM April 7, 1958 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Chestertown, Kent, Maryland | |
| 21. I certify that I attended the deceased from 4-7 , 19 58 to 4-14 , 19 58 that I last saw the deceased alive on 4-14 , 19 58 , and that death occurred at 4:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 4-14-58 | | | |
| ACTUAL SIGNATURE A.C. Dick | | M.D. _____ | |
| PHYSICIAN'S NAME (Type) A.C. Dick | | " " | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF 4/16/58 | 22c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory | 22d. LOCATION (City, town, or county) (State) Wilmington, Del. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | 24a. REC'D BY REGISTRAR DATE APR 16 '58 | |
| ADDRESS Chestertown, Md. | | 24b. REGISTRAR'S SIGNATURE W. S. Search | |

CERTIFICATE OF DEATH

2079

Reg. No. 114

| | | | | | | | | | | | | | | | |
|--------------------|--|-------------------|--|-------------------|--|-----------------|--|------------------|--|-------------------|--|----------------------|--|--------------------|--|
| PLACE OF BIRTH | | DATE OF BIRTH | | SEX | | RACE | | EDUCATION | | OCCUPATION | | MARRIAGE | | RELIGION | |
| NEW YORK | | JAN 1 1900 | | MALE | | WHITE | | HIGH SCHOOL | | LABORER | | MARRIED | | METHODIST | |
| PLACE OF DEATH | | DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVAILING DISEASE | | PREVAILING WEATHER | |
| NEW YORK | | JAN 1 1900 | | 10:00 AM | | HEART DISEASE | | SUDDEN | | ONE WEEK | | HEART DISEASE | | CLOUDY | |
| PLACE OF INTERMENT | | DATE OF INTERMENT | | TIME OF INTERMENT | | PLACE OF BURIAL | | NAME OF CEMETERY | | NAME OF MINISTER | | NAME OF FUNERAL HOME | | NAME OF UNDERTAKER | |
| NEW YORK | | JAN 1 1900 | | 10:00 AM | | NEW YORK | | NEW YORK | | NEW YORK | | NEW YORK | | NEW YORK | |
| NAME OF DECEASED | | DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVAILING DISEASE | | PREVAILING WEATHER | |
| JOHN DOE | | JAN 1 1900 | | 10:00 AM | | HEART DISEASE | | SUDDEN | | ONE WEEK | | HEART DISEASE | | CLOUDY | |
| NAME OF DECEASED | | DATE OF DEATH | | TIME OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVAILING DISEASE | | PREVAILING WEATHER | |
| JOHN DOE | | JAN 1 1900 | | 10:00 AM | | HEART DISEASE | | SUDDEN | | ONE WEEK | | HEART DISEASE | | CLOUDY | |

BUREAU V. S.

APR 16 1973

RECEIVED

4680

CERTIFICATE OF DEATH

04672

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 Kent Circle | | d. STREET ADDRESS 224 Kent Circle | |
| 3. NAME OF DECEASED (Type or print) First Vernon Middle M. Last Barnett | | 4. DATE OF DEATH Month Apr. Day 15 , Year 1958 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 27, 1870 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months 8 Days 7 Hours 19 Min. | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Route owner | | 10b. KIND OF BUSINESS OR INDUSTRY Public conveyance | |
| 11. BIRTHPLACE (State or foreign country) Delaware | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry Barnett | | 14. MOTHER'S MAIDEN NAME Nora McIlvaine | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Roy Barnett | | Address Chestertown, Md. son | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus pneumonia recurrent DUE TO Senile debility Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO Multiple epitheliomas of the skin PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 472x | | | INTERVAL BETWEEN ONSET AND DEATH 5 weeks 10 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 14, 1958 , to Apr. 15, 1958 , that I last saw the deceased alive on Apr. 14, 1958 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Geza Koralewski | | ADDRESS (Street, city or town, state) Millington, Md. | |
| PHYSICIAN'S NAME (Type) Geza Koralewski | | DATE SIGNED Apr. 16, 1958 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Apr. 18, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Chester Cem. | 22d. LOCATION (City, town, or county) (State) Chestertown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wells | | ADDRESS Chestertown, Md. | |
| 24a. REC'D BY REGISTRAR APR 17 58 | | 24b. REGISTRAR'S SIGNATURE Wells | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTIC

NAME OF LABORATORY

NAME OF PATHOLOGIST

NAME OF RADIOLOGIST

NAME OF HISTOLOGIST

NAME OF ANATOMIST

NAME OF ENTOMOLOGIST

NAME OF MICROBIOLOGIST

NAME OF IMMUNOLOGIST

NAME OF EPIDEMIOLOGIST

NAME OF STATISTICIAN

NAME OF LEGAL COUNSEL

NAME OF JUDGE

NAME OF CLERK

NAME OF ASSISTANT

NAME OF ATTENDING PHYSICIAN

NAME OF NURSE

NAME OF MIDWIFE

NAME OF DENTIST

NAME OF OPTICIAN

NAME OF PHARMACEUTIC

NAME OF LABORATORY

BUREAU V. S.

APR 17 1958

RECEIVED

4686

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Haven Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jacob Middle Chandler Last | | 4. DATE OF DEATH Month Apr. Day 9 Year 1958 | |
| 5. SEX M. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 20, 1874 |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Fishing | |
| 11. BIRTHPLACE (State or foreign country) Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jacob Chandler | | 14. MOTHER'S MAIDEN NAME Sarah Hawkins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-20-098 | |
| 17. INFORMANT Mrs. Caroline Gibson- | | Address Rock Hall, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular DUE TO (c) Atherosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH Instant |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 15, 1958 to April 9, 1958 , that I last saw the deceased alive on April 8, 1958 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Norbert C. Mitsch | | ADDRESS (Street, city or town, state) Rock Hall, Md. | |
| PHYSICIAN'S NAME (Type) NORBERT C. MITSCH | | DATE SIGNED APRIL-9/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Apr. 11, 58 | 22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery | 22d. LOCATION (City, town, or county) (State) Rock Hall, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | ADDRESS Chertertown, Md. | |
| 24a. REC'D BY REGISTRAR DATE APR 14 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | |

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BUREAU V. 3

APR 17 1958

RECEIVED
APR 17 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4687

CERTIFICATE OF DEATH

04674

Reg. Dist. No.

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Olivet Hill RFD | | /d. STREET ADDRESS Olivet Hill | |
| 3. NAME OF DECEASED (Type or print) First Catherine Middle Chew Last Chew | | 4. DATE OF DEATH Month 4 Day 5 Year 58 | |
| 5. SEX female | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 23, 1873 |
| 9. AGE (In years last birthday) 85 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | |
| 11. BIRTHPLACE (State or foreign country) Kent Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert Peaker | | 14. MOTHER'S MAIDEN NAME Alice Scott | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. N/O. | |
| 17. INFORMANT Violet Roane | | Address Galena, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 min years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 19 57 to Apr 5 , 19 58 that I last saw the deceased alive on Apr 5 , 19 58 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Apr. 7, 1958 | | | |
| ACTUAL SIGNATURE Wallace Obenshain M.D. | | | |
| PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. | | Cecilton, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/8/58 | 22c. NAME OF CEMETERY OR CREMATORY Olivet Hill Cem. | 22d. LOCATION (City, town, or county) (State) near Galena, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walby | | ADDRESS Chestertown, Md. | |
| 24a. REC'D BY REGISTRAR DATE APR 9 '58 | | 24b. REGISTRAR'S SIGNATURE Obenshain | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04675

Reg. Dist. No.

| | | | |
|---|---------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near - Galena c. LENGTH OF STAY IN 1b near- Galena d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Starkey Farms | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near- Galena d. STREET ADDRESS Starkey Farms e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles Dwyer | | 4. DATE OF DEATH April 23, 1958 | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 11, 1897 |
| 9. AGE (in years last birthday) 60 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY farm | |
| 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Dwyer | | 14. MOTHER'S MAIDEN NAME Julia James | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 200-24-6203 | |
| 17. INFORMANT Delia C. Dwyer | | 18. ADDRESS 43 Bellevue Trenton, N. J. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic cardio-vascular disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Several days several years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had a known coronary thrombosis in 1955 | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Robert W. Farr | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Robert W. Farr | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED April 24, 1958 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 26, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Greenwood Cem. | | 22d. LOCATION (City, town, or county) (State) Trenton, New Jersey | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells | | 24a. REC'D BY REGISTRAR APR 28 '58 | |
| ADDRESS Chestertown, Md. | | 24b. REGISTRAR'S SIGNATURE W. H. Smith | |

FOR STATE
HEALTH DEPT

BUREAU Y. E.

APR 28 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4681 CERTIFICATE OF DEATH

04678

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY KENT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Queen Anne's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN | | | | c. LENGTH OF STAY IN 1b 12 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHURCH HILL 17X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT + QUEEN ANNE'S HOSP | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARIE Middle C Last FREBURGER | | | | 4. DATE OF DEATH Month APR Day 19 Year 1958 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUL 31, 1882 | | 9. AGE (In years lost birthday) 75 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME George W. Grammick | | | | 14. MOTHER'S MAIDEN NAME Dorothea Lapus | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-20-0136 | | 17. INFORMANT HOSPITAL CHART | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIO-SCLEROSIS DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURES, BOTH LEGS 904.9 | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Apr 7 , 19 58 , to Apr 19 , 19 58 , that I last saw the deceased alive on Apr 19 , 19 58 , and that death occurred at 10:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE C. J. Keeffe | | M.D. CHESTERTOWN, Md. 4.19.58 | | | | | |
| PHYSICIAN'S NAME (Type) A. T. KEEFFE, JR., M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF April 23 | | 22c. NAME OF CEMETERY OR CREMATORY Budlersville | | 22d. LOCATION (City, town, or county) (State) Budlersville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane | | ADDRESS Church Hill, Maryland | | 24a. REC'D BY REGISTRAR DATE APR 23 '58 | | 24b. REGISTRAR'S SIGNATURE C. J. Keeffe | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|----------------------------|--|------------------------------|--|--------------------------|--|----------------------------|--|------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. PLACE OF DEATH | | 9. DATE OF DEATH | | 10. TIME OF DEATH | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | | 13. PERIOD OF ILLNESS | | 14. PREVIOUS ILLNESS | | 15. PREVIOUS SURGERY | |
| 16. SIGNATURE OF PHYSICIAN | | 17. SIGNATURE OF REGISTRAR | | 18. SIGNATURE OF WITNESS | | 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF NEXT OF KIN | |
| 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF NEXT OF KIN | | 23. SIGNATURE OF WITNESS | | 24. SIGNATURE OF PHYSICIAN | | 25. SIGNATURE OF REGISTRAR | |
| 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF NEXT OF KIN | | 28. SIGNATURE OF WITNESS | | 29. SIGNATURE OF PHYSICIAN | | 30. SIGNATURE OF REGISTRAR | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF NEXT OF KIN | | 33. SIGNATURE OF WITNESS | | 34. SIGNATURE OF PHYSICIAN | | 35. SIGNATURE OF REGISTRAR | |
| 36. SIGNATURE OF DECEASED | | 37. SIGNATURE OF NEXT OF KIN | | 38. SIGNATURE OF WITNESS | | 39. SIGNATURE OF PHYSICIAN | | 40. SIGNATURE OF REGISTRAR | |
| 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF NEXT OF KIN | | 43. SIGNATURE OF WITNESS | | 44. SIGNATURE OF PHYSICIAN | | 45. SIGNATURE OF REGISTRAR | |
| 46. SIGNATURE OF DECEASED | | 47. SIGNATURE OF NEXT OF KIN | | 48. SIGNATURE OF WITNESS | | 49. SIGNATURE OF PHYSICIAN | | 50. SIGNATURE OF REGISTRAR | |
| 51. SIGNATURE OF DECEASED | | 52. SIGNATURE OF NEXT OF KIN | | 53. SIGNATURE OF WITNESS | | 54. SIGNATURE OF PHYSICIAN | | 55. SIGNATURE OF REGISTRAR | |
| 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF NEXT OF KIN | | 58. SIGNATURE OF WITNESS | | 59. SIGNATURE OF PHYSICIAN | | 60. SIGNATURE OF REGISTRAR | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF NEXT OF KIN | | 63. SIGNATURE OF WITNESS | | 64. SIGNATURE OF PHYSICIAN | | 65. SIGNATURE OF REGISTRAR | |
| 66. SIGNATURE OF DECEASED | | 67. SIGNATURE OF NEXT OF KIN | | 68. SIGNATURE OF WITNESS | | 69. SIGNATURE OF PHYSICIAN | | 70. SIGNATURE OF REGISTRAR | |
| 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF NEXT OF KIN | | 73. SIGNATURE OF WITNESS | | 74. SIGNATURE OF PHYSICIAN | | 75. SIGNATURE OF REGISTRAR | |
| 76. SIGNATURE OF DECEASED | | 77. SIGNATURE OF NEXT OF KIN | | 78. SIGNATURE OF WITNESS | | 79. SIGNATURE OF PHYSICIAN | | 80. SIGNATURE OF REGISTRAR | |
| 81. SIGNATURE OF DECEASED | | 82. SIGNATURE OF NEXT OF KIN | | 83. SIGNATURE OF WITNESS | | 84. SIGNATURE OF PHYSICIAN | | 85. SIGNATURE OF REGISTRAR | |
| 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF NEXT OF KIN | | 88. SIGNATURE OF WITNESS | | 89. SIGNATURE OF PHYSICIAN | | 90. SIGNATURE OF REGISTRAR | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF NEXT OF KIN | | 93. SIGNATURE OF WITNESS | | 94. SIGNATURE OF PHYSICIAN | | 95. SIGNATURE OF REGISTRAR | |
| 96. SIGNATURE OF DECEASED | | 97. SIGNATURE OF NEXT OF KIN | | 98. SIGNATURE OF WITNESS | | 99. SIGNATURE OF PHYSICIAN | | 100. SIGNATURE OF REGISTRAR | |

RECEIVED
APR 23 1953
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4682

CERTIFICATE OF DEATH

04677

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | | | c. LENGTH OF STAY IN 1b <u>2 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Wilson</u> Last <u>Jones</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 8, 1918</u> | 9. AGE (In years last birthday) <u>39</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Isaac Wilson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Butler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-28-4465</u> | | 17. INFORMANT Address <u>Eva Wilson 121 Edward St., Chester, Pa.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right sided Cardiac decompensation</u> DUE TO <u>442x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uremia</u> DUE TO <u>3 days</u> (c) <u>hypertension</u> DUE TO <u>6 years</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular renal disease</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>58</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Feb 25, 1958</u> , to <u>April 24, 1958</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>58</u> , and that death occurred at <u>4:50</u> P.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Florence Deringer Joyce</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>4/24/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Florence Deringer Joyce</u> | | | | <u>Worton, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/26/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemty</u> | | 22d. LOCATION (City, town, or county) (State) <u>Worton, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> | | | | ADDRESS <u>Still Pond, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 28 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Overman</u> | | | |

BUREAU V. S.

APR 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4683

CERTIFICATE OF DEATH

04678

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RURAL | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN E MAGROGAN | | | | 4. DATE OF DEATH Month Day Year April 26 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH March 1899 | |
| 9. AGE (In years lost birthday) 59 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Embert | | | | 14. MOTHER'S MAIDEN NAME Sadie Eaton | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Address Hospital Records, Chestertown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage (Stroke) 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterial hypertension & Auricular fibrillation | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) | |
| 21. I certify that I attended the deceased from 4/24 , 19 58 , to 4/26 , 19 58 , that I last saw the deceased alive on 4/26 , 19 58 , and that death occurred at 9:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4/26/58 | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr M.D. Chestertown, Md. | | | | DATE SIGNED 4/26/58 | | | |
| PHYSICIAN'S NAME (Type) Robert W. Farr, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/30/58 | | 22c. NAME OF CEMETERY OR CREMATORY Church Hill Catholic Cem. | | 22d. LOCATION (City, town, or county) (State) Church Hill, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md. | | | | 24a. REC'D BY REGISTRAR DATE APR 30 '58 | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | |

CERTIFICATE OF DEATH

Reg. No. 14

| | | | |
|------------------------------|--|------------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES H. HARRIS | | APR 30 1958 | |
| AGE | | SEX | |
| 65 | | M | |
| RACE | | EDUCATION | |
| W | | H | |
| OCCUPATION | | CAUSE OF DEATH | |
| Carpenter | | Heart Disease | |
| PLACE OF DEATH | | MANNER OF DEATH | |
| Home | | Natural | |
| LOCALITY | | CITY | |
| Baltimore | | Maryland | |
| COUNTY | | STATE | |
| Baltimore | | Maryland | |
| DECEASED'S SIGNATURE | | DECEASED'S ADDRESS | |
| James H. Harris | | 1234 Main St, Baltimore, Md. | |
| DECEASED'S RESIDENCE | | DECEASED'S OCCUPATION | |
| 1234 Main St, Baltimore, Md. | | Carpenter | |
| DECEASED'S DATE OF BIRTH | | DECEASED'S DATE OF DEATH | |
| APR 30 1958 | | APR 30 1958 | |
| DECEASED'S PLACE OF BIRTH | | DECEASED'S PLACE OF DEATH | |
| Baltimore, Md. | | Baltimore, Md. | |
| DECEASED'S DATE OF ENTRY | | DECEASED'S DATE OF DEATH | |
| APR 30 1958 | | APR 30 1958 | |
| DECEASED'S PLACE OF ENTRY | | DECEASED'S PLACE OF DEATH | |
| Baltimore, Md. | | Baltimore, Md. | |
| DECEASED'S DATE OF DEATH | | DECEASED'S DATE OF DEATH | |
| APR 30 1958 | | APR 30 1958 | |
| DECEASED'S PLACE OF DEATH | | DECEASED'S PLACE OF DEATH | |
| Baltimore, Md. | | Baltimore, Md. | |
| DECEASED'S DATE OF DEATH | | DECEASED'S DATE OF DEATH | |
| APR 30 1958 | | APR 30 1958 | |
| DECEASED'S PLACE OF DEATH | | DECEASED'S PLACE OF DEATH | |
| Baltimore, Md. | | Baltimore, Md. | |

RECEIVED
APR 30 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4684 CERTIFICATE OF DEATH

04679

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hosp. | | d. STREET ADDRESS R FD | |
| 3. NAME OF DECEASED (Type or print) First Brenda Middle Meekins Last Meekins | | 4. DATE OF DEATH Month Apr. Day 9 Year 1958 | |
| 5. SEX female | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 23, 1957 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 11. BIRTHPLACE (State or foreign country) Kent Co. Md. | |
| 13. FATHER'S NAME Arthur W. Meekins | | 14. MOTHER'S MAIDEN NAME Irene Layfield | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs. Irene Meekins | | Address Mother Chestertown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Constrictive Heart Failure DUE TO (c) Myocarditis | | | INTERVAL BETWEEN ONSET AND DEATH 8 hours 12 hours ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 4/1 , 19 58 , to 4/9 , 19 58 , that I last saw the deceased alive on 4/9 , 19 58 , and that death occurred at 8 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Thomas J. Solon M.D. | | ADDRESS (Street, city or town, state) Chestertown, Maryland | |
| PHYSICIAN'S NAME (Type) Thomas J. Solon | | DATE SIGNED 4/9/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Apr. 11, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Chester Cem. | 22d. LOCATION (City, town, or county) (State) Chestertown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells | | 24a. REC'D BY REGISTRAR APR 11 '58 | |
| ADDRESS Chestertown, Md. | | 24b. REGISTRAR'S SIGNATURE W. Search | |

2072242XV4

CERTIFICATE OF DEATH

1933

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|-------------------|--|--------------------|--|--------------------|--|------------------------|--|---------------------|--|----------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | | PREVIOUS TOBACCO | | PREVIOUS OTHER | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF JUDGE | | SIGNATURE OF CLERK | | SIGNATURE OF REGISTRAR | | SIGNATURE OF VENDOR | | SIGNATURE OF WITNESS | | SIGNATURE OF OTHER | | SIGNATURE OF OTHER | | SIGNATURE OF OTHER | | SIGNATURE OF OTHER | | SIGNATURE OF OTHER | | SIGNATURE OF OTHER | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |

BUREAU V. S.

APR 11 1933

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04680

Reg. Dist. No.

| | | | | | |
|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Kent</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Worton</i> | | c. LENGTH OF STAY IN 1b <i>Life</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Worton</i> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS (Butlertown Section) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <i>EDWARD</i> Middle <i>RILEY</i> Last | | | 4. DATE OF DEATH Month <i>April</i> Day <i>8</i> Year <i>1958</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Colours</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>? ? 1899</i> | | 9. AGE (In years last birthday) <i>79</i> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Colours</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>William Riley</i> | | | 14. MOTHER'S MAIDEN NAME <i>Harriett</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Don't Know</i> | 17. INFORMANT <i>Caddie Brown</i> Address <i>Worton, Md.</i> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Unknown but probably natural cause</i> <i>795.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Robert W. Farr</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <i>4/8/58</i> | |
| EXAMINER'S NAME (Type) <i>Robert W. Farr</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>4/10/1958</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Butlertown Cem.</i> | 22d. LOCATION (City, town, or county) <i>Worton, Md. RFD</i> (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth W. W. Farr</i> ADDRESS <i>Chestertown, Md.</i> | | | 24a. REC'D BY REGISTRAR <i>APR 10 58</i> | 24b. REGISTRAR'S SIGNATURE <i>W. W. Farr</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 10 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4690

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>Kent</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marley (Rural)</i> | | c. LENGTH OF STAY IN 1b <i>none</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <i>314 Bank Lane</i> | |
| 3. NAME OF DECEASED (Type or print) <i>ESTELLE THOMPSON</i> | | 4. DATE OF DEATH <i>4 26 1958</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Jan 1, 1916</i> |
| 9. AGE (in years last birthday) <i>42</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Delaware</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>WALTER POORE</i> | | 14. MOTHER'S MAIDEN NAME <i>LENA WILLIS</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Raymond Thompson</i> | | Address <i>Dover Del (husband)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple severe injuries; chest</i> 823X DUE TO (b) <i>abdomen, pelvis, head, extremities</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>None</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Front seat passenger in car which ran off road & struck a tree</i> | |
| 20c. TIME OF INJURY Month, Day, Year <i>May 4 1958</i> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i> | | 20f. (City or town) <i>New Marley, Kent Ind.</i> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Robert W. Farr</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried May 1, 1958</i> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Old Village Cem</i> | | 22d. LOCATION (City, town, or county) <i>Smyma</i> (State) <i>Del.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward William Mullington md.</i> | | 24a. REC'D BY REGISTRAR <i>1 '58</i> | |
| | | 24b. REGISTRAR'S SIGNATURE <i>W. B. Search</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.
1

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Usual Residence: _____

7. Date of Death: _____

8. Time of Death: _____

9. Place of Death: _____

10. Cause of Death: _____

11. Manner of Death: _____

12. Signature of Medical Examiner: _____

13. Signature of Coroner: _____

14. Signature of Registrar: _____

15. Signature of Physician: _____

16. Signature of Nurse: _____

17. Signature of Pathologist: _____

18. Signature of Forensic Scientist: _____

19. Signature of Toxicologist: _____

20. Signature of Anthropologist: _____

21. Signature of Radiologist: _____

22. Signature of Psychiatrist: _____

23. Signature of Social Worker: _____

24. Signature of Chaplain: _____

25. Signature of Funeral Home: _____

26. Signature of Cemetery: _____

27. Signature of Burial: _____

28. Signature of Interment: _____

29. Signature of Reinterment: _____

30. Signature of Other: _____

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04682

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>218 Lynhburg</u> | | d. STREET ADDRESS <u>1718 Lynhburg St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Simon</u> First Middle Last <u>TILGHMAN</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 1890</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charley Tilghman</u> | | 14. MOTHER'S MAIDEN NAME <u>Sottie Frisby</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.I.</u> | | 16. SOCIAL SECURITY NO. <u>W.W.I.</u> | |
| 17. INFORMANT <u>Martha Chalmers</u> Address <u>Chestertown, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable congestive heart failure</u> (b) <u>Short of breath, dependent edema for several months. Not able to go up & down stairs for a month. Found dead suddenly at 4 PM</u> (c) <u>434.1</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Robert W. Farr</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/24/58</u> | |
| EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4/26/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u> | | 24a. REC'D BY REGISTRAR <u>APR 28 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78
NEED AN EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. E.

APR 28 1958

RECEIVED

4691

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Kent MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Piney Neck | | d. STREET ADDRESS Piney Neck | |
| 3. NAME OF DECEASED (Type or print) First Lola H. Middle Wilson Last | | 4. DATE OF DEATH Month Apr. Day 17 Year 1958 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 11, 1903 |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY farming | |
| 11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frances Hollock | | 14. MOTHER'S MAIDEN NAME Anna Caroline Steel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Charles A. Wilson, Rock Hall, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE C. J. Keefe, M.D. M.D. ACTING DEPUTY MED. EXAMINER | | | |
| PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. CHESTER TOWN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 29 / 58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery | | 22d. LOCATION (City, town, or county) (State) near Fairlee Kent Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams | | 24a. REC'D BY REGISTRAR APR 21 58 | |
| ADDRESS Chesertown, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

